Mental Welfare Commission for Scotland

Report on announced visit to:
The State Hospital, Lewis and Mull Hubs, 110 Lampits Road, Carstairs, Lanark, ML11 8RP

Date of visit: 20 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The State Hospital is the national high-secure forensic hospital for individuals from Scotland and Northern Ireland. All individuals in the hospital are under the Mental Health (Care and Treatment) (Scotland) Act, 2003 or the Criminal Procedure (Scotland) Act, 1995; they are highly restricted in relation to freedoms that would normally be expected by individuals in other hospital or community settings.

The Commission visits the State Hospital at a minimum of once per year to give individuals, their relatives, and staff an opportunity to speak with us. The hospital comprises of four units (hubs), with either two or three wards in each.

Since our last visit, the units/hubs remain broadly unchanged and continue to adopt a clinical care model that has reduced Mull hub from three to two wards with Mull 3 remaining closed. Mull comprises of two transition wards whilst Lewis has one admission/assessment ward with two treatment and recovery wards.

At the time of our visit, there were 56 individuals in the hubs.

We last visited Lewis and Mull hubs in June 2024 for an announced visit. We wanted to follow up on the issues identified from the previous visit, and on matters that have been brought to our attention since then. We also wanted to give individuals an opportunity to speak with us regarding their care and treatment, and to ensure that care and treatment was being provided in line with mental health legislation and on a human rights compliant model.

On our last visit, we made recommendations relating to the clinical team meeting records noting who was in attendance, that all care plans should be completed consistently with the views of the named person and relatives reflected and the ward environment was redecorated. The response we received from the service was that steps were being taken to ensure that these matters were addressed.

Who we met with

We met with 14 people and reviewed their care records. We also spoke with four relatives.

Prior to the visit, we held virtual meetings with the director of nursing, the associate nurse director, the associate medical director and the senior charge nurses for the hubs. On the day of the visit, we met with the senior charge nurses (SCNs), various allied health professionals (AHPs), the Skye Centre manager and nursing staff on each of the wards we visited.

Commission visitors

Justin McNicholl, senior manager (projects)/social work officer

Anne Craig, social work officer

Kirsty Macleod, engagement and participation officer (carers)

Anne Buchanan, nursing officer

Gordon McNelis, nursing officer

Denise McLellan, nursing officer

Catriona Neil, ST6 Learning Disability Psychiatry on placement at the Commission

What people told us and what we found

At the time of our visit to the hubs, many of the people were either in the wards due to their level of restriction or undertaking activities in the Skye Centre. We were able to visit and observe people in all of the hubs without any issues. The majority of the people that we spoke with commented that the hospital was a good hospital to be in.

We heard from individuals that they were given clear information on admission and if they had any questions, these could be answered by various members of the clinical staff.

We received mostly positive comments about the various staff. Nursing staff were described by several individuals as “good”, “very good”, “helpful”, “easy to get on with” and “understanding”. Several people talked about having a named nurse and of being able to speak with them at least once every two to three weeks, depending on the member of staff’s shift pattern. Most individuals found the staff “approachable”, “warm” and “caring”. We heard a range of comments about staff which included; “the staff have helped my progress, they have been amazing”, “the staff here are more understanding than anywhere else” and “it’s been a really positive move”. One individual stressed the transformative approach staff had taken, “the staff are the best of the best, they all deserve medals”.

Some spoke of their doctor positively, “hands down the best doctor I’ve ever had”, “he is a nice person”, “he has made such a difference to my mental health” and “since having a change in my doctor I’ve been getting better”. Other individuals praised the work of psychology staff, “she is always listening, with a plan for my recovery and rehabilitation” and “I’ve got really good input from them”.

Some individuals and their families spoke of their issues with their allocated doctor, “wouldn’t be my first choice”, “we have a difference of opinion” and “we had significant concerns about the inconsistencies in plans”. One relative gave an account of their experience as a named person, “we were genuinely scared to escalate our concerns to the doctor, we felt dismissed and our role was ignored, but since he has a new doctor, what a significant improvement. We are invited to CPAs every time, we are listened to and can ask any questions”.

The majority of people we spoke to were positive about their future and their care goals, with plans in place for onward progress from the hospital to lower levels of security. This included individuals being clear on their escorted and unescorted time in the hospital grounds and to the Skye Centre. Individuals provided positive comments on the food in the Hospital stating, “they have a very good selection”, “the food is great” and “no complaints, I like the food”.

Many of the people we spoke to in the hubs and in the Skye Centre indicated that they liked the community meetings which were reported to be available in all the

wards. Individuals described these as “informative” and helped to influence the patient participation group (PPG) which meets at the Skye Centre. One individual advised that they did not have access to community meetings when in Lewis 1 but this was now available in their current ward.

In previous visits to the State Hospital, concerns were raised about people being confined to their bedrooms due to staff shortages. This was defined as daytime confinement (DTC). During this visit no one raised any concerns about being confined to their bedroom, with individuals advising that there was no recent requirement for the ward to use DTC as staff numbers had improved. Managers advised us of their plans to end the use of DTC by 1 October 2025. When we next visit, we look forward to hearing whether this goal has been achieved.

When we asked people to describe how they felt in the hubs, many stated that they felt “safe”, “secure”, “respected” and “protected”. Several individuals whose mental health had improved since their admission described how staff managed situations well, including those who were subject to enhanced observation levels. One individual stated, “they cope well with looking after unwell folk who are not aware of what’s going on around them; they always reckon to manage impact on ward”.

Several individuals spoke of never hearing about or seeing a care plan and this feedback was shared with managers. In other hospitals, it is routine practice for care plans to be shared and signed by people, but this is not the practice in the State Hospital.

Those individuals who received input from psychology staff discussed having sessions on a one-to-one basis or in a group setting. One individual spoke of not being sure if he would have to undertake further psychological work but was aware of how to find out about this with staff in the coming weeks.

We heard from one individual of his wish to attend a clinical team meeting (CTM), where all aspects of his care and treatment plans were discussed. The individual was aware that this was not how the State Hospital currently organised CTMs but reflected on how he found this to be a positive experience in other hospitals. We agreed to feed this back to managers for consideration.

When we spoke with the extended management team, we heard that there is a plan to open Mull 3 ward to accommodate females who will be cared for at the hospital. This new service has resulted in an increase in staff to support the service. The impact of this on Lewis and Mull hubs was described by people as an “unknown change” as several staff from the two hubs were moving permanently to Mull 3. We received some comments that certain members of staff would be “missed”, “she is a really good charge nurse” and “I’m a little worried of what this all means”. We heard that despite this significant change in the service there remains a stable senior

management team, senior nursing staff and allied health professionals (AHPs) in place.

The importance of relatives and named persons is critical for those who find themselves subject to detention in hospital. Many of the individuals we met with during this visit had no named person or relative involvement. Despite this, they spoke of the positive engagement and support they received on a weekly basis from independent advocacy. Some people spoke of having an advance statement which ensured their wishes for treatment were recorded and adhered to, when possible, by their treating team.

On this occasion, we took the opportunity to meet with the lead manager for the Skye Centre and to visit the services that were in place. We spoke with staff and people who were engaging in activities and asked what the service was like. The visit provided an opportunity to obtain a better understanding of the specific remit of the professionals who work in the centre and who provided input to the four units/hubs of the hospital. The feedback we received while visiting the Skye centre from those that we spoke with was positive.

When we met with staff, they spoke of the positive support that the psychotherapist provided to them. This included the opportunity for reflective practice sessions in which they are able to discuss, on a peer-to-peer basis, any specific issues that arise in their practice.

Care, treatment, support, and participation

Care records

Similar to our last visit, information on individuals' care and treatment continues to be held on the fully integrated electronic system, RIO. We found this to be responsive, easy to navigate, and it allowed all professionals to record their clinical contact in one place.

We found most care records were detailed and comprehensive. There was clear and consistent evidence of one-to-one sessions that occurred between individuals and their named nurse. We noted that those individuals who were involved in the same group sessions with occupational therapy or with nursing staff had the same entries in their notes. We fed back to managers and asked them to consider whether an individualised approach for recording activities was feasible, depending upon the numbers involved in the group sessions. They agreed to discuss this further with staff.

The Hospital Electronic Prescribing Medicines Administration (HePMA) system was in place across all wards. From the records we accessed, recordings on this were found to be clear and accurate.

The risk assessments in the wards were all undertaken to a high standard which included detailed recording of historical, clinical and risk management-20 (HCR -20) reports, as well as the risk of sexual violence protocol (RSVP) reports, when appropriate, which assisted with the transfer of individuals moving to a lower level of security when deemed appropriate.

We noted that there a clear understanding in the clinical team meeting (CTM) of the need to address diversity and inclusion of those individuals whose first language was not English. This understanding extended to the need to capture the impact that trauma had on the people in the hospital. We found mostly that there was flexibility and adaptability in the records made by staff, who were focused on ensuring a culture of sensitivity and positive language when describing individuals.

Due to the level of restrictions in the hospital, there is the potential to have in place the most restrictive means of caring for people, i.e. the use of enhanced levels of direct observation or seclusion. However, we found that in the notes, a range of non-pharmacological interventions were considered which ensured that it was as a last resort that highly restrictive measures, such as use of soft mechanical restraint or seclusion, were considered. For those subject to soft mechanical restraint, we were able to find clear and detailed reasons for this and evidence of regular reviews by staff not based in the ward that ensured these minimised the risks to the individuals involved.

We found good evidence and record keeping relating to the input provided by speech and language therapists, music and art therapists.

We found that all individual records that we reviewed had care and treatment plans in place to support admission goals, outcomes and identified plans of care. These were stored on the electronic recording system, RIO.

In the State Hospital there is an expectation that all nursing care plans are reviewed monthly. Since our previous recommendation, we found this target was now being achieved in Lewis and Mull hubs compared to what we found on our last visit.

The nursing care plan reviews had a clear focus on risks and on the progress of the individual. In our review of the care plans, we noted that individuals in the hospital had a wide range of complex mental and physical health needs. Individuals had multiple plans to support all aspects of their care and treatment. We were pleased to see that there was a clear and distinctive focus on physical health especially for those who required specialist input due to their specific needs.

The information in the care plans we reviewed provided a clear understanding as to what intervention was necessary to provide the support required. The only gap we noted in the nursing care plans was that there was no evidence of family

involvement despite a number of individuals having significant input from a named person and/or relative.

When we asked people about their nursing care plans, they generally did not know what we meant. In other hospitals we usually find consistent evidence that individuals would sign or choose not to sign care plans. Currently this is not the practice in the State Hospital which means that there are differences between individuals and the staff regarding care goals. Despite this, we had no concerns regarding the care plans and how they linked with the CTM minutes.

We found that those subject to enhanced observation levels, soft mechanical restraint or seclusion had specific care plans which were designed to address the reduction in these measures as soon as possible.

Multidisciplinary team (MDT)
Lewis and Mull hubs held regular multidisciplinary team (MDT) meetings, referred to as clinical team meetings (CTM). We found these meetings to be well structured, with decisions taken in a timely way, and all recordings detailed clearly and concisely.

Each ward CTM was made up of nursing staff, psychiatrists, social work, occupational therapy, speech and language therapy, physiotherapy, dietetics, psychology, and pharmacy staff. It was clear from the thorough CTM meeting notes that all professionals were involved in an individual's care and treatment and were invited to attend the meetings where they provided comprehensive updates on their involvement.

No people or relatives attend the CTM. Instead, each individual's keyworker meets with the person prior to and following the CTM, to ensure their views and requests were discussed. Similar to our visit to Lewis and Mull hubs in June 2024 and Arran and Iona in November 2024, we did not find the names of the members of staff who attended the CTM. We were advised these were held on a Microsoft Teams platform and could be accessed at any point. We requested the names of those at the latest CTM on the day of the visit from the nursing staff and no one knew how to access this information for our visit. We have previously made a recommendation about the lack of clarity on who is attending this as it is important that the names of those who are making important decisions about care and treatment are recorded. We raised this gap in recording once again with the managers to ensure that there is a clear and consistently accessible way in which to record who is present at a CTM. We are therefore repeating our previous recommendation.

Recommendation 1:
Managers should ensure that all clinical team meetings record the name and designation of all in attendance and these are accessible at all times.

We found evidence that delayed discharges and those subject to excessive security appeals were discussed at MDT and care programme approach (CPA) meetings. Bed capacity in the hubs was not an issue on the day of our visit. The exact number of individuals waiting on a move to a lower level of security changes regularly. We were aware from speaking to people that they feel delayed for prolonged periods of time and were in hospital for months longer than needed due to difficulties in securing suitable medium and low secure placements. Of those individuals who were in the hospital at the time of our visit, we were told that three could have had their care needs met in a lower level of secure care.

We saw physical health care needs were being addressed and followed up swiftly and appropriately and all relevant physical health monitoring was in place. The point of access for individuals requiring urgent health care is through a contracted general practitioner (GP), who visits the hospital twice a week. The GP service provided treatment of minor ailments, which reduced the number of times individuals had to leave the hospital to access secondary care services. The hospital continues to employ a practice nurse who was available across the hospital site to address any minor health issues that patients may face on a daily basis. This role ensured that access to the GP was used appropriately.

Use of mental health and incapacity legislation

Individuals at the State Hospital are subject to restrictions of high security; all patients require to be detained either under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act) or the Criminal Procedure (Scotland) Act, 1995 (Criminal Procedure Act).

The individuals we met with during our visit had a clear understanding of their detained status. All individuals that we met with, reported that they had advocacy support and legal representation. We heard from individuals who told us “I am planning to make an excessive security appeal”, “I have a solicitor and know I’m going to Rowanbank next”; “I plan to speak to my lawyer to challenge my CORO, it’s too restrictive”.

All documentation relating to the Mental Health Act, the Criminal Procedure Act, and Adults with Incapacity (Scotland) Act, 2000 (AWI Act), including certificates around capacity to consent to treatment as well as suspension of detention, were found on RIO and were up to date.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Medication was recorded on the hospital electronic prescription management application (HePMA) and matched what was recorded on the consent

to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act. We found some evidence of duplication with T2 and T3 forms in place prescribing the same medication. We found one person in Lewis 2 whose PRN prescribed medication was not authorised by a T3 form. The findings were shared with the associated medical director who agreed to address these matters. The rest of the forms that we reviewed were completed by the responsible medical officer (RMO) and were found to be in order.

Any individual who receives treatment under the Mental Health Act or the Criminal Procedure Act can choose someone to help protect their interests; that person is called a named person. Where an individual had nominated a named person, we found copies of this in their file. We spoke to two named persons who were clear on their roles and associated rights.

Rights and restrictions

Due to its high secure status, The State Hospital operates airport-style security checks for all visitors, along with strict monitoring of all movements around the hospital via CCTV overseen by the hospital security staff.

All hubs operate a locked door policy which is commensurate with the level of risk identified with the individual group.

A number of the people that we reviewed and met with were subject to enhanced levels of observation. Some of these people were being nursed in side-rooms or in the day rooms of the wards; this way of nursing individuals was put in place to support their safety or that of others. All the observations that we witnessed on the day of our visit were being delivered in line with good practice. There was no one subject to seclusion in the hubs.

We observed and met those who were subject to the use of soft restraint kits (SRK) and who were on enhanced observations throughout the use of these measures. This was to ensure the safety of the individual and to allow for additional monitoring of their physical and mental health. The use of SRK can result in individuals feeling significantly restricted, causing discomfort and undignified positioning. An individual that we observed was subject to wrist and mid-belts. The Commission is required to be informed of all use of SMR, and we reminded the service to maintain these notifications.

Advocacy in the hospital is delivered by the Patients Advocacy Service (PAS). The feedback on the advocacy service was very positive and we heard this during our meetings with individuals. There was consistent advocacy input to the hospital at various meetings held throughout the service. We made contact with the advocacy manager and heard that the service continues to be well used and is valued. We saw from the care records that advocacy attended the ward regularly and supported

individuals who were involved in tribunals, in their discharge planning and CPA meetings.

When we are reviewing an individual's records, we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On this visit we found advance statements were in place where appropriate. When a decision was taken to override the wishes of the individual, this was fully recorded and the appropriate notifications made.

The Commission has regularly highlighted the significant difficulties with regard to 'individual flow' across the forensic estate. The situation of individuals in the hospital awaiting moves to lower levels of security remains an issue that continues to be addressed by Scottish Government and the Forensic Network in terms of a capacity review. The Commission has produced *Appeals against detentions in conditions of excessive security* good practice guidance which can help individuals, their named person, relatives and staff navigate this complex area.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where an individual is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. By virtue of the high secure environment, all individuals in the state hospital are automatically specified for safety and security, telephones and correspondence. The individuals we spoke with were aware of these restrictions and the impact on their stay in hospital. Since our last visit we have published an updated *Specified persons* good practice guide for clinicians to access.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We were pleased to find that there remains a strong focus on activity in the Hospital, supported by the Occupational therapy staff, Skye Centre and nursing staff.

From those that we spoke with, we heard that they were encouraged to participate in a variety of activities, in and outside the hubs. All of the people we spoke to in the hubs praised the activities that were available to them. Individuals spoke of the patient participation group (PPG). This is a group of individuals, who are

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

representatives for the ward they are based in; the PPG chair is elected by their peers. This appears to be working well, and we met with the chair who discussed their role. The group meets weekly to consider any issues, concerns, or suggestions people have. There are then regular community meetings that take place on each ward. The PPG meetings were minuted and allowed all individuals to discuss issues and make suggestions that related to their particular ward. The ongoing role of the PPG is a positive aspect for the hospital as it ensures that participation is being actively promoted on a regular basis.

The majority of individuals have access to a range of recreational and therapeutic activities through the Skye Centre, which is adjacent to the hubs. We visited the centre which has a learning centre, the greenhouse, a vocational room, the gym, recreational hall, a hairdresser suite and an animal care centre.

The centre provides the opportunity for people to undertake Scottish Vocational Qualifications (SVQ's) in volunteering as well as other subjects. The Skye Centre maintains a welcoming atrium area that provides individuals with the opportunity to be in an environment where they can meet for a chat with staff and have a refreshment. We observed people undertaking a variety of activities including the running of a recycling initiative called Nu2u. This allows people to purchase or rent pre-used clothing, televisions, books and DVDs as well as other items.

We were able to observe an arts and crafts class where people were painting, drawing and making clay moulds. Individuals' artwork can be considered for the Koestler arts awards, which take place on an annual daily.

These activities provided positive outcomes for the people taking part.

Similar to our previous visits, we noted that staff were aware of the importance of physical exercise which helps to increase mental wellbeing and physical health. On the day of visit the Centre was holding a sports award week. This provided individuals the opportunity to nominate those who had taken part in a specific activity i.e. table tennis, bowls, cycling or running. The feedback from individuals was that they benefitted from the input of the various sport volunteers.

Throughout the visit we saw staff and individuals moving throughout the hospital for various activities and meetings. Despite how busy the wards seemed, we noted that many of the people were relaxed and comfortable with the staff on shift.

The physical environment

We were pleased to find that our poster notifying people of our visit was displayed in the hubs.

The physical environments of Lewis and Mull hubs were unchanged from previous visits. The units compromise of a nurses' station, a dining room, kitchen, day room

area, offices and side rooms. The wards have single en-suite bedrooms and access to a secure garden area. We heard from individuals that depending on the weather and their security status, they are allowed use of the patio area and dedicated garden space.

During this visit we found the wards to be clean and tidy. Similar to our last visit, a number of the walls in the day room area and at the nurses' stations required painting. Several of the walls in the day room had old sticker marks as well as cracked paint on them. We found some of the walls had drawings, writings, smiley faces and doodles. We did not think that this would be welcoming for new individuals arriving in the ward. We again raised this with managers as it was a recommendation from our last visit that the hospital action plan should have been addressed. We recommended that managers ensure work is undertaken to address this and prioritised at pace. We discussed the environmental issues with managers and look forward to seeing how their plans for improvements have progressed when we next visit.

Recommendation 2:
Managers must prioritise the redecoration of the wards to ensure the environment remain welcoming for both individuals being cared for in the hospital and staff.

While visiting Lewis 3, we noted that the modified strong room (MSR) has a broken blind in place. This cannot be adjusted by staff or individuals placed in this room. The impact of this is that people who are secluded in this room have a decreased level of dignity as individuals walking past the room from the outside can see in. If an individual is acutely unwell or seeking to have increased or decreased levels of daylight then this cannot be accommodated. We were informed that the replacement of this blind would cost a significant amount of money as the blind cannot be replaced on its own, instead the entire window frame requires to be removed. We alerted managers to our concerns regarding the privacy of individuals placed in this environment and requested that this is addressed.

Recommendation 3:
Managers should seek to repair the broken blind in the modified strong room (MSR) of Lewis 3.

Summary of recommendations

Recommendation 1:
Managers should ensure that all clinical team meetings record the name and designation of all in attendance and these are accessible at all times.

Recommendation 2:
Managers must prioritise the redecoration of the wards to ensure the environment remain welcoming for both individuals being cared for in the hospital and staff.

Recommendation 3:
Managers should seek to repair the broken blind in the modified strong room (MSR) of Lewis 3.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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